California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
Fax (916) 327-6308
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GRAY DAVIS, GOVERNOR

NONRESIDENT PHARMACY PERMIT APPLICATION

Please print or type **ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A**

Name of Pharmacy:	Pharmacy Telephone Number ( )

Address of Pharmacy: Street and Number City State Zip Code

Indicate whether this application is for:

☐ New Pharmacy ☐ Change of Location of an existing pharmacy ☐ Change of Ownership of an existing pharmacy

If this is a **change of ownership** or **change of location**, indicate previous name, address and license number of pharmacy.

Date of proposed change of ownership or location:

Please indicate type of ownership:

☐ Individual ☐ Partnership ☐ Corporation ☐ Not-for-profit corporation ☐ Government owned

Name of agent for service of process in California	Agent's telephone number ( )

Agent's California address (P.O. box not acceptable) City State Zip Code

Toll-Free Telephone Number for patient-pharmacist communication 1-888 1-800	Resident State pharmacy permit # & date issued

Do you mail replacement contact lenses to patients in California? Yes ☐ No ☐

By your affirmative answer above, your pharmacy name will be provided to the California Medical Board and you will be in compliance with section 4124 of the California Business and Professions Code.

CONTINUE ON REVERSE

FOR OFFICE USE ONLY

STAFF REVIEW			**CASHIER LOG**
☐ Articles of Incorp	☐ Financial Aff	Approved _____	Cashier # _____
☐ Partner agreement	☐ Stock Cert	Denied _____	Date _____
☐ Seller's certificate	☐ By-laws	Date _____	Amount of fee _____
☐ Whlse agreement	☐ Lease		

Name of pharmacist-in-charge			Pharmacist license number
Residence address	City	State	Zip code
Indicate if you want all correspondence mailed to a different address. If correspondence should be mailed to the pharmacy, please insert "Same as Pharmacy."			
Name and telephone number of contact person to clarify information provided on this application. ( )			

PLEASE READ CAREFULLY

This application must be approved by the California State Board of Pharmacy before a pharmacy permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.
The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the Executive Officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Section 1798.3 of the Civil Code.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an executive officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate; and (5) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

_____	_____	_____
Signature of corporate officer, partner or owner	Name (please print)	Title
_____	_____	_____
Signature of corporate officer, partner or owner	Name (please print)	Title
_____	_____	_____
Signature of corporate officer, partner or owner	Name (please print)	Title

_____
Date